

Written Testimony of

The Hon. Kathy Patterson

D.C. Auditor

prepared for the

Council of the District of Columbia

Committee on Health

Department of Health Performance Oversight Hearing

February 20, 2020

Room 412

The John A. Wilson Building

1350 Pennsylvania Avenue NW

Washington DC 20004

Submitted February 18, 2020

Councilmember Gray, I am sharing this written testimony from the Office of the D.C. Auditor (ODCA) to be included in the record for the Department of Health Performance Oversight Hearing on February 20, 2020. I also have provided a copy to Dr. LaQuandra Nesbitt, Director of the D.C. Department of Health.

### **ODCA Nursing Home Oversight Report**

On September 30, 2019, ODCA released an audit report entitled, [D.C. Department of Health Has Systems to Monitor Nursing Homes But Some Risks Remain](#). A copy of the report is included with this testimony.

ODCA audited the Department of Health (DOH) Health Regulation and Licensing Administration (HRLA) oversight of nursing homes because nursing home residents are a vulnerable population. We selected the audit at our discretion, based on our authority in D.C. Code § 1-204.55.

This report was mostly positive, but recommended improvements in several areas. DOH agreed or partially agreed with six of the 10 recommendations and is already making progress implementing several of these. This testimony focuses on four remaining areas of concern:

1. At some nursing homes, the same problems keep recurring.
2. DOH uses illegible records to monitor nursing home staffing levels.
3. DOH needs written procedures that describe how to assign a complaint the correct priority.
4. DOH does not require nursing homes to show that residents have consented before they are moved.

#### **1. At some nursing homes, the same problems keep recurring.**

The most concerning problem that DOH declined to address was the recurrence of specific issues in some nursing homes, including not providing enough supervision, failing to follow physician's orders related to respiratory conditions, and leaving electrical components exposed. These problems have harmed residents during the audit scope and more recently. Our research also found that even though nursing homes typically submitted two plans to correct problems—one under D.C. law and one under federal law, as required—the Plans of Correction did not address the problems' causes and as such were unlikely to prevent recurrence. DOH HRLA accepted these Plans of Correction, which might have been why we found problems that recurred during the audit scope.

In response to Recommendation 2 on page 33, DOH disagreed with our recommendation to ensure that the recurring problems had stopped (recommendation 2, page 10) and partially agreed (response to recommendation 1, page 31) with our recommendation to make sure that a nursing home's Plan of Correction addressed the root cause of the problem (recommendation 1, page 10). The repeats originally identified in our report were a lack of supervision and deficiencies in oral care at Washington Center, deficiencies in following physician's orders related to respiratory status at Deanwood, and exposed electrical components and lack of fingernail and toenail care for some residents at Bridgepoint Capitol Hill. We identified these repeats by looking at six nursing homes for three years. Recently, DOH reported that it was implementing the recommendation to make sure that the repeated problems had been fixed at Washington Center, Deanwood, and Bridgepoint Capitol Hill. A review of recent inspection reports<sup>1</sup> reveals that lack of supervision, deficiencies in following physician's orders related to respiratory status, and exposed electrical components have recurred at the respective nursing homes

---

<sup>1</sup> DOH publishes many of the inspection reports and Plans of Corrections for nursing homes on its website at <https://dchealth.dc.gov/node/182492>

since the conclusion of the audit scope, all of which are concerning problems, and one of which led to a resident falling and breaking his leg in July 2019.

Addressing root causes is a best practice that ODCA uses in its work. A recommendation we make is most likely to be effective if it addresses the root cause of the problem, and a nursing home's Plan of Correction similarly would be most effective if it addressed the problem's root cause. In its partial agreement with our recommendation, DOH wrote that it would retrain staff on the federal requirements for a Plan of Correction, which it did not interpret to include addressing cause (report pages 31-33). However, D.C. requires its own Plans of Correction to address root causes, and nothing in federal law restricts the District from requiring the corrective action to encompass root causes. The Committee may wish to consider such a requirement.

### **Recurrences have continued since the audit scope ended in September 2018.**

A Washington Center resident broke his leg when a group of residents was left unattended in the solarium on July 7, 2019. The individual fell out of his wheelchair, fracturing his femur, the largest bone in the leg. The fracture was discovered three days later, and the resident was then transferred to the emergency room. DOH accepted a Plan of Correction from the nursing home to address the lack of supervision by training all staff on supervising residents in the solarium. The Plan was very similar to Plans DOH had accepted before for inadequate supervision, including for incidents resulting from inadequate supervision in the solarium. DOH had identified inadequate supervision at Washington Center twice in 2016, and once in 2017, and like the most recent instance, one of the previous instances also resulted in harm to a resident requiring transfer to the emergency room. Overall, DOH found evidence of inadequate supervision at Washington Center four times in the last four years, raising the question of whether inadequate staffing might be the root cause in such incidents rather than inadequate training.

At Deanwood, DOH inspectors found in March 2019 that the oxygen concentrator filter for one resident was covered with dust, despite physicians' orders stating it must be rinsed with water, patted dry, and reinstalled. The resident was not made sick by the dust but could have been. Our report found that inspectors had identified problems carrying out physicians' orders related to respiratory status twice already, in 2016 and 2017 inspections, for a total of three recurrences in four years.

At Bridgepoint Capitol Hill, a DOH inspector found that two electrical outlets were missing their cover plates in August of 2019. No residents were hurt, but they could have been, because live wires were exposed. DOH found exposed electrical components at least twice before at Bridgepoint Capitol Hill: missing switch plates in May of 2017 and missing outlet cover plates in June of 2018, for a total of at least three instances.

### **2. DOH uses illegible records to monitor nursing home staffing levels.**

To promote the health and safety of D.C.'s nursing home residents, at what were then some of the poorest performing nursing homes in the nation, the D.C. Council created nursing home staff-to-resident ratio requirements in the Health Care Facilities Improvement Act of 2009. Most of the requirements that DOH HRLA oversees at nursing homes are federal, and the federal requirements do not include staffing ratios.

The D.C. law directs the Mayor to "require nursing facilities to...provide a minimum daily average of 4.1 hours of direct nursing care per resident per day, of which at least 0.6 hours shall be provided by an advanced practice registered nurse or registered nurse, which shall be in addition to" a physician,

physician assistant, or advanced practice registered nurse who is “available on-site for a minimum of 0.2 hours per week for each resident at the facility.”<sup>2</sup>

We found that some of the staffing records that nursing homes gave DOH to review were illegible, so DOH could not use them to determine if nursing homes had enough staff to provide quality care. In fact, DOH HRLA staff often had to ask nursing homes, who have a vested interest in appearing to comply, to tell them what the staffing records said.

DOH disagreed (response to recommendation 5, page 34) with the recommendation in the audit to require nursing homes to submit legible records of staffing for its review (recommendation 5, page 15). It is not clear if or how DOH plans to monitor compliance with D.C. law for staffing ratios without legible staffing records. Illegible staffing records in general and repeated problems with inadequate supervision at Washington Center specifically raise concerns that DOH’s oversight process for the staffing requirements is insufficient, leading to direct consequences for nursing home resident safety and health.

### **3. DOH needs written procedures that describe how to assign a complaint the right priority.**

Another area of concern we found in our report is that DOH did not have written policies and procedures for prioritizing complaints, which led to assigning a low priority to tips that should have prompted rapid investigation (Recommendation 4, page 10). DOH agreed with our recommendation to develop policies and procedures and referenced federal written standards but did not describe plans to develop its own written policies and procedures (Response to recommendation 4, page 34). DOH has instituted weekly meetings about complaints, which likely improves coordination. DOH recently reported this recommendation as completed but did not provide ODCA with a copy of the policies and procedures.

### **4. DOH does not require nursing homes to show that residents have consented before they are discharged or transferred.**

DOH did not receive signed notices for resident discharges and transfers from the nursing home before some moves occurred. Without a signed notice, DOH had no evidence that the resident was aware of and had consented to the move.

Our audit recommended that DOH require nursing homes to submit signed copies of the discharge and transfer notices before all moves occur (except in emergencies, see recommendation 7 on page 19). DOH disagreed with our recommendation to require the signatures but agreed to request that nursing homes submit evidence of resident notification and consent before non-emergency moves (response to recommendation 7, page 35). DOH also outlined a plan to develop procedures for recording telephone consent.

### **Suggested questions for DOH HRLA**

#### *Recurring problems*

1. Please describe the steps that DOH HRLA took to ensure resident health and safety at the following nursing homes with the described recurrence of a single issue:
  - a. At Washington Center, for the inadequate supervision of residents identified in the inspection completed on July 30, 2019, which had occurred at least three times previously in the past four years.

---

<sup>2</sup> D.C. Code § 44-504 (h-1)

- b. At Deanwood, for its failure to follow physicians' orders related to respiratory care for residents identified in the inspection completed on March 26, 2019, which had occurred at least three times in the past four years.
  - c. At Bridgepoint Capitol Hill, for exposed electrical components identified in the inspection completed on August 15, 2019, which had occurred at least three times in the past four years.
2. Washington Center submitted and DOH accepted a Plan of Correction to address the July 2019 incident where the nursing home left residents unsupervised and one fell and broke his leg. That Plan of Correction is similar to other Plans of Correction Washington Center submitted for previous problems with inadequate supervision. Why do you think additional training will address the lack of supervision when that has not prevented the recurrence previously? Could the recurrence result from inadequate staffing instead of inadequate training?
  3. Would you support a District requirement that root causes be identified as part of the corrective planning process? If not, please explain why not.
  4. What resources does DOH need and what resources does DOH anticipate nursing homes will need to correct the recurrent problems identified in the ODCA report?
  5. Please describe any additional steps DOH is planning to ensure inspections are effective in leading to long-term correction of problems.

*Illegible staffing records*

6. Since the release of the ODCA report, what changes has DOH made to its process for monitoring staffing levels at nursing homes? Has the legibility of nursing home staffing records improved in FY 2020 inspections completed to date?
7. How do you know that nursing homes are providing the staffing ratios that D.C. Code requires to make sure that residents receive the care they need? What steps are you planning to ensure all D.C. nursing homes provide the number of direct care staff required by law?
8. In its comments on the audit report, DOH wrote that "there is no regulation to require a facility to implement a standardized [staffing] form." What resources or authority does DOH need and what resources does DOH anticipate that nursing homes will need to be able to implement the recommendation to maintain legible, standardized staffing records? Would you like the Council to legislate in this area?

*Policies and procedures for assigning complaints the right priority*

9. Have written policies and procedures for prioritizing nursing home complaints been completed? If yes, please provide a copy to the Committee. If they have not been complete, please provide their current status and expected completion date.
10. Has complaint investigation timeliness improved since the ODCA audit was released? If yes, please provide details. What other steps is DOH planning to ensure that complaints are prioritized correctly so that they will be investigated as rapidly as they should be.

*Showing the residents have consented before they are moved*

11. Has DOH requested that nursing homes submit signed copies of resident transfer and discharge notices before the proposed move (except in an emergency)? If so, how many have been provided before the resident moved? Please describe the steps DOH is planning to ensure that it monitors resident notification and consent for moves outside the nursing home.

Thank you for the opportunity to share ODCA's recent work and questions suggested by our report. We are happy to provide any additional information that might be useful.